MDR Tracking Number: M5-04-2983-01

Under the provisions of Section 413.031 of the Texas Workers' Compensation Act, Title 5, Subtitle A of the Texas Labor Code, effective June 17, 2001 and Commission Rule 133.305 titled Medical Dispute Resolution - General and 133.308 titled Medical Dispute Resolution by Independent Review Organizations, the Medical Review Division (Division) assigned an IRO to conduct a review of the disputed medical necessity issues between the requestor and the respondent. The dispute was received on May 11, 2004.

The IRO reviewed CPT Codes 95925, 95861, 95851, 95831, 95832, 97110, 99213, 97014, 97250, 97265, 97150, 97140, 99354, 97530, and 97035 for dates of service 06/11/03 through 10/27/03 that were denied based upon "U" and "V".

The Division has reviewed the enclosed IRO decision and determined that **the requestor did not prevail** on the majority of the medical necessity issues. Therefore, the requestor is not entitled to reimbursement of the IRO fee.

CPT Codes 95925, 95861 and 95851 for dates of service 06/11/03 and 06/23/03 were found to be medically necessary. CPT Codes 97110, 99213, 97250, 97265, 97150, 97140, 97530, 97014, 97035, 95831, 95832, 95851, and 99354 for dates of service 07/28/03 through 10/27/03 **were not** found to be medically necessary. The respondent raised no other reasons for denying reimbursement for CPT Codes 95925, 95861, 95851, 95831, 95832, 97110, 99213, 97014, 97250, 97265, 97150, 97140, 99354, 97530, and 97035.

Based on review of the disputed issues within the request, the Medical Review Division has determined that **medical necessity was not the only issue** to be resolved.

On April 20, 2004, the Medical Review Division submitted a Notice to requestor to submit additional documentation necessary to support the charges and to challenge the reasons the respondent had denied reimbursement within 14-days of the requestor's receipt of the Notice.

- CPT Code 99080 for date of service 09/23/03 denied as "V". Per Rule 133.106 the Commission has jurisdiction over required reports. Per Rule 133.106(f)(2) the requestor has submitted the narrative report to support services were rendered as billed. Reimbursement in the amount of $70.00 is recommended.

- CPT Code 99080-73 for date of service 09/23/03 denied as "V". Per Rule 129.5 the TWCC-73 is a required report and is not subject to an IRO review. The Medical Review Division has jurisdiction in this matter; therefore, reimbursement in the amount of $15.00 is recommended.

On this basis, and pursuant to §§402.042, 413.016, 413.031, and 413.019 of the Act, the Medical Review Division hereby ORDERS the respondent to pay the unpaid medical fees in accordance with the fair and reasonable rate as set forth in Commission Rule 133.1(a)(8) plus all accrued interest due at the time of payment to the requestor within 20-days of receipt of this Order. This Order is applicable to dates of service 07/28/03 through 10/27/03 in this dispute.

The respondent is prohibited from asserting additional denial reasons relative to this Decision upon issuing payment to the requestor in accordance with this Order (Rule 133.307(j)(2)).

This Decision and Order is hereby issued this 29th day of October 2004

Marguerite Foster
Medical Dispute Resolution Officer
Medical Review Division

MF/mf

Enclosure: IRO decision

September 3, 2004

NOTICE OF INDEPENDENT REVIEW DECISION

RE: MDR Tracking #: M5-04-2983-01
TWCC #:
Injured Employee:
Requestor:
Respondent:
------ Case #:

------ has been certified by the Texas Department of Insurance (TDI) as an independent review organization (IRO). The ------ IRO Certificate Number is 5348. Texas Worker's Compensation Commission (TWCC) Rule §133.308 allows for a claimant or provider to request an independent review of a Carrier's adverse medical necessity determination. TWCC assigned the above-reference case to ------ for independent review in accordance with this Rule.

------ has performed an independent review of the proposed care to determine whether or not the adverse determination was appropriate. Relevant medical records, documentation provided by the parties referenced above and other documentation and written information submitted regarding this appeal was reviewed during the performance of this independent review.

This case was reviewed by a practicing chiropractor on the ------ external review panel who is familiar with the with the condition and treatment options at issue in this appeal. The reviewer has met the requirements for the ADL of TWCC or has been approved as an exception to the ADL requirement. The ------ chiropractor reviewer signed a statement certifying that no known conflicts of interest exist between this chiropractor and any of the treating physicians or providers or any of the physicians or providers who reviewed this case for a determination prior to the referral to ------ for independent review. In addition, the ------ chiropractor reviewer certified that the review was performed without bias for or against any party in this case.

Clinical History

This case concerns a 39 year-old male who sustained a work related injury on ------. The patient reported that while at work he was moving cable and felt pain in both wrists. Initially the patient was treated with a short course of physical therapy. The patient was referred to an orthopedic specialist who performed a removal of a right wrist ganglion cyst. On 6/11/03 the patient

underwent an EMG/NCV study that revealed a mild left C7 radiculopathy. A MRI of the right and left wrist performed on 5/7/03 indicated a ganglion cyst dorsal aspect of the wrist just dorsal to the articulation between the scaphoid and the trapezoid (right wrist), and de Wuervain's tenosynovitis, and intra-osseous cyst involving the proximal fifth metacarpal (left wrist). The diagnoses for this patient have included post surgical arthropathy, bilateral wrist sprain/strain grade II, and myofascial pain syndrome. Further treatment of this patient's condition has included manual therapy, ultrasound, therapeutic activities, electrical stimulation and therapeutic procedures.

Requested Services

Somatosensory testing, electrical tomography, ROM, muscle testing, therapeutic exercises, special reports, office visits, electrical stimulation, myofascial release, joint mobilization, therapeutic procedures, manual therapy, prolonged physical services, therapeutic activities and ultrasound from 6/11/03 through 10/27/03.

Documents and/or information used by the reviewer to reach a decision:

Documents Submitted by Requestor:

1. Summary of Injury
2. EMG/NCV study 6/11/03
3. Office notes 6/6/03 – 10/27/03
4. MRI report 5/7/03

Documents Submitted by Respondent:

1. No documents submitted

Decision

The Carrier's determination that these services were not medically necessary for the treatment of this patient's condition is partially overturned.

Rationale/Basis for Decision

The ------ chiropractor reviewer noted that this case concerns a 39 year-old male who sustained a work related injury to both wrists on ------. The ------ chiropractor reviewer indicated that the patient was initially evaluated on 5/5/03 and recommended treatment to bilateral wrists for the diagnoses of de Quervain's syndrome. The ------ chiropractor reviewer noted that the patient was referred out to an orthopedic surgeon on 5/20/03. The ------ chiropractor reviewer indicated that an initial FCE performed on 5/7/03 and a follow up FCE on 6/23/03. The ------ chiropractor reviewer explained that the follow up FCE showed the patient to have decreased right wrist grip strength, left and right wrist range of motion, bilateral wrist flexion and extension strengths, bilateral radial deviation strength and right ulnar deviation strength since the previous FCE. The ------ chiropractor reviewer indicated that these decreases demonstrate the patient was not benefiting from the treatment plan provided. The ------ chiropractor reviewer also indicated that at that point the treatment plan should have been modified. The ------ chiropractor reviewer

explained that the patient should have been placed in a less strenuous home exercise program with emphasis on stretching of the wrist and thumb rather than strengthening that could cause aggravation to the injury. The ------ chiropractor reviewer noted that on 6/20/03 the patient was evaluated by the orthopedic surgeon and placed in bilateral wrist braces and discontinued physical therapy for two weeks to due to the patient's increased pain level. The ------ chiropractor reviewer explained that 6 weeks of therapy for nonsurgical tenosynovitis is reasonable and appropriate treatment (Association of Orthopedic Surgeons Guidelines and The Official Disability Guidelines). Therefore, the ------ chiropractor consultant concluded that the somatosensory testing, electrical tomography, ROM, muscle testing, therapeutic exercises, special reports, office visits, electrical stimulation, myofascial release, joint mobilization, therapeutic procedures, manual therapy, prolonged physical services, therapeutic activities and ultrasound from 6/11/03 through 6/23/03 were medically necessary to treat this patient's condition. However, the ------ chiropractor consultant further concluded that the somatosensory testing, electrical tomography, ROM, muscle testing, therapeutic exercises, special reports, office visits, electrical stimulation, myofascial release, joint mobilization, therapeutic procedures, manual therapy, prolonged physical services, therapeutic activities and ultrasound from 6/24/03 to 10/27/03 were not medically necessary to treat this patient's condition.

Sincerely,

State Appeals Department